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ABSTRACT

This paper, one in a series of occasional publications, discusses the role of the midwife, or "daya," in contemporary Egypt. The series is intended to increase understanding of the interrelationships between population growth and socioeconomic and cultural patterns throughout the world, and to communicate this understanding to scholars and policy makers. The following questions are discussed: (1) How is the traditional midwife faring in Egypt, a country where modern medicine has been practiced for many decades and where maternal and child health and family planning services are within reach of most inhabitants? (2) How have her role and her practices evolved and adjusted in the face of competition from modern medical practice? (3) What forms of interaction exist between her and the public health personnel? (4) How does she view family planning activities and is there any way in which she can be induced to help rather than to obstruct family planning efforts? (Author/RM)

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THE DAYA OF EGYPT

SURVIVAL IN A MODERNIZING SOCIETY

Laila El-Hamamsy*

All cultures have ways of preserving their accumulated wisdom and of transmitting it from generation to generation, along with whatever modifications are inspired by new experience and new knowledge. Literate societies can create permanent repositories of specialized knowledge that are not usually part and parcel of the generally learned and transmitted cultural heritage. In preliterate cultures, however, certain individuals with prescribed roles assume the function of books and archives and act as the repositories and preservers of the specialized cumulative knowledge and lore of the group. It is not within the sphere of technology that these specialists are usually found, for as long as it is rudimentary, technological knowledge is generally shared and is passed from generation to generation through the normal socialization process within the basic of unit society, the family. It is rather in the sphere of intangibles—of beliefs, of interpretations of the meaning of life and death, of the place of man in the cosmos, of health and sickness—that the preservers of specialized knowledge seem to emerge. They are those individuals who learn, interpret and preserve the relevant oral traditions, rituals and practices necessary to maintain a harmony between man and the forces which surround him. The priest, the medicine man, the *shaman*, the magician, are among such categories of individuals.

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*I would like to express my thanks and gratitude to Mrs. Nawal El Messiri Nadim who as my research assistant collected all the field data for this paper. Without her help, I would not have come to know and appreciate so well our little acclaimed village *daya*.

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These usually acquire their roles through long apprenticeship at the hands of their masters. Often enough, novices are recruited from among family members, thus leading to the monopoly of such roles by certain families in the community. The fascinating description of the teachings of Don Juan by Carlos Caslaneda depicts very well the long and arduous process the apprentice may have to endure in order to acquire the powerful knowledge of the specialist—in this case *el brujo* or sorcerer.

These important roles, however, are seriously challenged when modern science and technology are introduced into traditional societies. Scientific knowledge tends to narrow down the areas of the unknown and the supernatural and puts to question the validity of traditional interpretations of life's phenomena. New experts, armed with superior technology, emerge to threaten the power, prestige and the livelihood of the traditional wise men and practitioners. These naturally react to the threat that the new knowledge presents and maneuver to preserve their privileged statuses and roles. I believe that the struggle between the old and the new passes through several phases. At each phase the traditionalists may use different approaches, or maneuvers, to defend themselves against the threat of the new ideas and practices—the survivors being those who use the right tactics at the right time.

At a very early stage in the introduction of an innovation, the traditionalists are usually self-confident. They are capable of defending themselves without much effort since they have on their side all the weight of custom and belief and the unproven worth of the new ideas. At this juncture, it is usually the innovators who must move gingerly and ingeniously to make an impression. A second stage is reached when some people begin to see value in the new technique or innovation; at this point the resistance of the traditionalists becomes sharpened and aggressive, with no holds barred. The threat is clearly perceived, but there is still a chance for tradition to retain the upper hand. Then comes the stage when the new, in part or whole, makes serious incursions and the threat to traditional practices becomes a reality. It is at this point that the wise ones survive and the less malleable are left behind, losers. Survival often means compromise, or the modification of the tradition in such a way as to integrate the best of the new while maintaining the special qualities of the old. The modernizers, having not yet completely entrenched themselves, may also find compromise their wisest policy. A final stage may be reached when tradition completely loses out and the distinction between the traditional practitioner and the modern professional totally disappears; the *shaman* then becomes the M.D. and the magician the scientist.

This paper deals with one category usually omitted from ethnographic descriptions of the key preservers of life's wisdom, that is, the midwife. Perhaps it is because her role has to do exclusively with women and has

little to do with public life, or an obvious power position, that she has been given little serious attention. However, it is the midwife who attends to the birth of life and it is she who, by ritual and prescription, preserves and propagates understandings on the creation and preservation of nascent life and reinforces traditional attitudes towards conception and procreation.

The main questions being posed in this paper are: how is the traditional midwife or *daya* faring in Egypt, a country where modern medicine has been practiced for many decades and where maternal and child health and family planning services are within reach of most inhabitants? How have her role and her practices evolved and adjusted in the face of competition from modern medical practice? What forms of interaction exist between her and the public health personnel? How does she view family planning activities and is there any way in which she can be induced to help rather than to obstruct family planning efforts?

My interest in the role of the *daya* developed in the course of studying factors affecting attitudes towards family planning within a village in the heart of the Egyptian Delta. A factor that seemed worthy of consideration was the influence of special interest groups on family planning awareness and acceptability. Obviously, among these were the traditional village midwives or *dayas*. Since pregnancy and childbirth are the bases of their livelihood and position in the community, the *dayas* are expected to have a pronatalist influence. Such influence can be widespread since their contacts with village women are continuous and intimate and, unlike those of family planning workers, need no special explanation or effort.

Prior to the field study, discussions were held with senior officials of the Ministry of Health about the role of the traditional *daya* and its relationship to maternal and child health services. According to them, the traditional *daya* is on the way to complete extinction. There was a time when an enlightened Ministry, recognizing the impossibility of providing adequate maternal and child health services for all the population, took sufficient interest in the traditional *daya* to provide them with from six months to one year of practical training in obstetrics. At the successful completion of the training, the *dayas* were then licensed and the more promising ones employed as assistants in the Public Health MCH (Maternal and Child Health) clinics. This training program had started as early as the 1940s. Unfortunately, however, in 1969 the Ministry of Health changed its policy; all licenses were revoked and the practice of training the *dayas* was discontinued. This action was based on the conviction that the *dayas* had become redundant, since large numbers of trained *hakimas* (nurse/midwives) and assistant *hakimas* had become available. According to the Ministry's statistics, there are at present 2400 *hakimas* and 11,000 assistant *hakimas*. A survey of the study village (population 14,000) revealed

that, contrary to the assertions of the Ministry of Public Health, the *dayas* have not disappeared in the rural areas. Surprisingly enough, 14 practicing *dayas* were found in the village, their ages ranging from 30 to 65, in addition to one retired *daya* said to be 100 years old. They were all illiterate, but 8 of them had had from 6 to 12 months training at one of the midwifery training centers of the Ministry of Health.

Whereas on the national level plans are under way to liquidate the position of *daya*, the public health personnel in the field fully recognize her importance and consider her the indispensable arm and extension worker of the MCH program. They admit freely that without the *daya* they would not be able to serve their public in any but the most limited fashion. It does not take much imagination to recognize that one general practitioner and one *hakima** cannot possibly attend to all child deliveries in a community where, on the average, approximately 600 babies are born per year. The field study indicates that the *dayas* and the public health personnel have managed to evolve a modus vivendi that involves not just peaceful coexistence but a truly cooperative and symbiotic relationship.

The *hakima* of the Public Health Center speaks of her relationship to the village *dayas* as one of real collaboration:

> There is a continuous work relationship between the *dayas* and me. They are extremely helpful to me. I always contact the *dayas* to register all the pregnant women under their care and they cooperate extensively with us.

There are prescribed rules of the game governing the relationship between the *daya* and the medical and paramedical personnel, to which everyone seems to adhere. According to the *hakima* her responsibilities are as follows:

> I visit the women every day for a week after childbirth. If there are any complications I call the doctor. The doctor does not attend to any child deliveries. If there are any serious complications I call the ambulance to get the women to the hospital in the town. The responsibility of the doctor is in prenatal care—he gives a medical check up and examines the heart and the blood pressure.

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*The usual staff of the Health Center in the village.

The cooperation between the *hakima* and the *daya* is, according to the former, based on the following division of labor:

> First of all, I go to the *daya* and take down the names of pregnant women under their care in order to register them in the MCH clinic. The *dayas* help us a great deal. We cannot locate the people nor find their addresses, but the *dayas* know their way. It is also very rare for me to attend to a child delivery by myself. The *daya* is always present. Each family has a special *daya* who also takes care of the *sebou'* (seventh day childbirth celebration). In truth, there is no competition whatsoever between me and the *daya* because it is she who takes the money and the tips but we take nothing; therefore, it is the *daya* herself who calls on me. She is afraid not to call me for fear of getting penalized. Actually, she always tries to stay in my good books. The families living outside the village amongst the fields must depend on the *daya*: they send a donkey to bring her over and she goes and delivers their babies.

The above statement alludes to another ingredient in the delicately balanced relationship between *daya* and professionals, i.e. the power MCH personnel have over the *dayas*. Since the *dayas* practice their trade illegally, MCH personnel can informally impose on them rules and procedures that the latter feel compelled to follow for fear of legal action against them.

The *hakima* in this particular village is actually so enthusiastic about the work of the *dayas* that she herself admits:

> The *dayas* here and elsewhere are so clever that I personally have a *daya* deliver me; I do not like to have a *hakima* attend to my childbirths. I guide many of the *dayas* and they need us. They take from us medical supplies such as mercurochrome, bandages and lysol. Sometimes the *daya's* bag is even better equipped than mine. There were only two deliveries I have ever performed without a *daya*, one was for the daughter of the *Omda* (mayor) and the other for a female government employee.

Even though the *dayas* themselves admit that the paramedicals and doctors possess superior knowledge and techniques and have greater prestige "because they are educated," yet, the *dayas* are not afraid of them as competitors. Actually, they have no reason to be since ninety percent of all child deliveries in the village are handled by *dayas*. The latter are also

secure in the knowledge that they perform a variety of important functions and services, other than midwifery, that can never be taken over by modern professionals—namely, the psychological, the ritualistic and the occult.

For their part, the *dayas*, especially the trained ones, have learned to exploit the Public Health Center and other available modern health facilities to great advantage and find every good reason for cooperating closely with the MCH clinic personnel. First of all, the latter are willing, despite the edicts of the Ministry of Health, to allow the *daya* to practice her trade and to collect the fees for her services. Secondly, the *dayas*, along with the public, are aware of modern medical practice and respect and value it. They find it in their interest to use the facilities and services of the MCH clinics and hospitals when in trouble. Finally, the *daya* needs to have someone share the responsibility, or even to become the scapegoat in case of mortality, morbidity or the birth of an abnormal child. According to the village doctor, some *dayas* "always take the *hakima* with them so that they may share with them the responsibility."

Whereas the personnel of the MCH clinic do not have a competitive relationship with the *daya*, the one private doctor in the village does. He does not seem to stand up under the competition, however, for a number of reasons. First of all, he takes high fees and may collect from three to four Egyptian pounds per case ($4.50-$6.00).* The *daya*, on the other hand, may receive less than a pound ($1.20) for her services and these, as will be noted later, may include a great deal more than simply attending to childbirth. Secondly, as a male, the doctor is not totally acceptable to the conservative rural women. Furthermore, even though a doctor inspires respect and even awe, in his clients, he is remote and is in no position to provide all the social and psychological support women require during pregnancy and childbirth. He himself complains about his inability to attract clients. "I have been here for years and I have only had ten pregnant women come and seek my services directly and most of these were teachers or government workers. But the people of the village do not come to me; they prefer the *dayas*."

Still, both the *daya* and the doctor, though fearing and resenting the competition, seem to have found it in their interest to work out a compromise—an uneasy one at times, but a reasonably harmonious one at others. The *daya*, respecting the doctor's superior knowledge, seeks him when her knowledge fails to meet the situation. He, knowing that he needs her to get him clients, accepts her role, albeit grudingly. The doctor explains the situation as follows:

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*One Egyptian pound = 100 piastres or $1.20.

> The *daya* gets in touch with me only when she is faced with a serious case of difficult labor. However, she always tells her clients that she is calling for the doctor only in order that he may give some injections. She always likes to stay on after I get there, whether I like it or not. I personally do not try toembarrass her or get her angry, because if I do she will never call on me again. She will send the case to the emergency hospital or get another doctor and that would harm me.

He recognizes the fact that the *daya* sees him as her competitor:

> Once a woman became pregnant after 12 years of marriage. When it was time for the delivery, they called on Zahira, the *daya*. The labor proved difficult and the husband called me in secret. Zahira was surprised to find me walk in and she was angry. She called the mother of the woman and said, "What is he going to do? Your daughter is going to have the baby normally, but in this way you are just inviting bad luck."* She is of course right in feeling that I threaten her livelihood. Before I came to this village, Om Said used to take money from the doctor whenever she referred a client to him, but I give her nothing. However, I try to keep her happy by allowing her to clothe the baby and to dress up the woman so that relatives may give her something .... Cases of difficult labor are sometimes referred to the hospital in town. I would be there myself but the *daya* tries to stay on until the woman goes into the delivery room, in order to impress the relatives that the woman only needs injections and that it is she who will still deliver the child. In such situations, I usually throw the *daya* out.

We turn now to a detailed description of the ramified functions of a village *daya*, dealing first of all with the question of who becomes a *daya* and how.

The main attribute a woman should possess to become a *daya*, according to the majority of *dayas* interviewed, is to have the profession inherited within her own family. "It is not important for a woman to be married, to be a widow or a divorcee; if she has a *daya* in her family, naturally she can become a daya." "If a woman's mother is a *daya*, this is quite enough for her to become a *daya*. She needs nothing else!" "A clever and clean

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*The idea being that having thought of or talked about something unpleasant, you bring it about.

woman can become a *daya* but a *daya* whose ancestors are *dayas* has a special position." In fact, we find 13 out of the 14 village *dayas* have inherited their profession through the family—through the mother, aunt, mother-in-law, etc.

Om Said, a woman of 65, is the most respected *daya* in the village. The way in which she became a *daya* is typical of how most of the *dayas* learn their trade. Om Said naturally comes from a family of *dayas*. Her mother and paternal aunt were *dayas* and they had inherited their profession from Om Said's paternal grandmother. Om Said's daughter, niece and sister-in-law are likewise *dayas*. Om Said became a *daya* through the encouragement of her mother who, according to her daughter, was "a *daya* of the aristocracy." Her mother at first tried to train her in midwifery by taking her along when she attended child deliveries, but Om Said was not particularly enthusiastic about learning the trade. At the age of 17, however, her mother enrolled her, along with her cousin, in the midwifery training school in the nearby town of Menouf. She was by then already married and had had a child; she had to leave her daughter in her mother's care in order to attend the training course. Because of her aptitude, she was recruited after completing six months of training as an assistant to the *hukima* in the School Health Center in the town of Shebin, the capital of the governorate, where she remained for three years. Her daughter in the meantime continued to live with her mother. When the health unit was transferred to another town she refused to move and returned to work in the Health Center of her own village. She worked there for three years, then decided to leave in order to assist her mother as a village midwife. She continued to do so until her mother's death, when she began to practice alone. Om Said explains her reason for leaving the Health Center as follows, "I found that I could earn through one delivery the 138 piasters (2 dollars) I used to receive as monthly salary." However, she does not seem to have regretted the fact that she had worked in the Health Center. Quite the contrary, for she constantly boasts about having had the privilege of working with doctors. She feels it places her in a class above the *dayas* who have not had a similar experience. We find her speaking like a true snob, when she refers to an untrained *daya* as, "this ignorant woman, this uncouth peasant!"

The following are the various functions and responsibilities of the *daya* from the moment a pregnant woman becomes a client. It must be made clear from the outset that not every *daya* necessarily performs all the functions and services mentioned below; many of course do, but others are more selective.

Prenatal Care

The *daya's* relationship with a pregnant woman may start during the early months of pregnancy. Some women check with the *dayas* upon suspicion of pregnancy; these are usually newlywed and childless women, anxious to find out if they are pregnant. Other women, unless they have ailments or complications, summon the *daya* only during the ninth month of pregnancy or when already in labor. As one woman explained, "So long as one is well, there is no reason to get in touch with the *daya* before the delivery." Another said, "I got in touch with the *daya* during the last month of pregnancy in order that she may attend to the delivery. I had no complications, so I did not need her before that."

Thirty-three women, selected at random, were interviewed about their relationship to the *daya*. Thirty-two of them had been delivered by a *daya* and only one by a doctor. The former were asked about their first contact with the *daya* during their last pregnancy. Twenty-one women stated that they had summoned her on the day of the delivery only; five said they had contacted her during the last month of pregnancy; the remaining six said that the *daya* had been in continuous touch with them during their pregnancy. Interestingly enough, the last six were all the clients of the best trained *daya* of the village, Om Said.

The women said that Om Said asked about their health as soon as she learned that they were pregnant. She encouraged them to go to the MCH clinic for a checkup and prenatal care. She herself explains how she induces the women to do so. "I tell the pregnant women, 'If you do not register yourselves at the clinic, then when you are about to have the child and you call for the clinic personnel to come, nobody will pay you any attention.'"

Asked about their contacts with Om Said during pregnancy, a number of her clients gave the following typical answers:

> The *daya* would know when I am pregnant and whenever she passes near our house she would ask about me until the day I am ready to have the baby. When I feel the labor pains, I send for her and she comes immediately.
>
> I get in touch with Om Said so that she can take me to the Health Center in order that they may give me medicines after I have the baby.
>
> I contact the *daya* just before the delivery. But before that, throughout the pregnancy, she keeps asking about me and if she hears that I have any ailment, she comes to see me and tells me to go to

the Health Center.

During my last pregnancy I contacted her from the fourth month and she kept running after me asking me, "How is your health.?" I was not feeling well so she advised me to go to the Health Center.

Om Said's training had obviously taught her to appreciate the importance of antenatal care. In this, as well as in all her other practices, Om Said is an example of how well the old and the new can meet in a realistic and felicitous compromise that works to everyone's benefit—that of the village women, of the *dayas* and of the medical professionals.

When a pregnant woman is not feeling well, but does not exhibit what the *daya* and the women themselves view as serious symptoms, the *daya* may herself prescribe the cure, such as rest, hot beverages, a purge, etc. Some *dayas* apply traditional remedies, such as feeding a woman who feels mild, premature labor pains eggs fried in oil in the belief that such symptoms are due to her having smelled the odor of fried bean cakes or frying fat.

The public recognizes the *dayas* competence as a midwife, but in case of serious ailments accompanying pregnancy, it is the Health Center or the doctor they consult. The following are typical statements by village women:

I get in touch with the *daya* during the last month of pregnancy; if I don't feel well, I go to the doctor.

I get in touch with the *daya* only when I am having the baby, because she can do nothing else but help in child delivery. If I do not feel well during the pregnancy, I call a doctor right away to give me pills or an injection.

I contacted the *daya* only a few hours before childbirth because she does not know how to treat illnesses; she knows how to deliver babies only.

However, some of the women do go to the *daya* for advice. It is often she who refers them to the professionals and may even accompany them to the MCH clinic. "If a woman is pregnant and wants to go to the clinic," says one *daya*, "I go with her and give nothing (that is, money) to the doctor or the *hakima*." The fact is that the *daya* herself does not like to handle serious complications nor venture to treat illnesses. She would rather leave the responsibility to the doctors, the paramedicals and, when appropriate,

to the "health barbers" (traditional health practitioner).

The better trained *dayas* are able to recognize serious pregnancy problems. Om Said lists what she regards as serious complications and explains how she handles them in the following terms:

> Morning sickness you can do nothing about. If the pregnant woman bleeds, I have no business with that; I tell her to go to the doctor. . . . If the fetus stops moving for a period of time, then I tell her to consult the clinic. If a woman has swollen feet and belly, I know she has albumin in the urine. I take her immediately to the clinic because if she does not receive treatment the baby will be affected and the swelling will overwhelm her and may kill her. If the pregnancy is not normal, that is something we can only tell during child delivery.

A pregnancy that ends in miscarriage or abortion will be handled by the *daya* so long as the abortion occurs quickly and without complications; otherwise, the woman is referred to hospital.

> If a woman has an abortion and comes to me and there is blood and no pain, I tell the woman to sleep on her back. If the abortion comes easily, I stay with the woman until she aborts. If it looks difficult, I inform the hospital. My daughter (also a *daya*) was having an abortion and I informed the hospital and they took her in an ambulance. I did not get in touch with the MCH clinic in the village, because they cannot handle abortions.

Child Delivery

When a woman is ready to have her baby, she sends for the *daya;* the *daya* stays with her until the baby is born. As labor proceeds, the *daya* gives the woman hot milk, soup, cinnamon, or other hot beverage, or feeds her eggs fried in oil to help speed up the labor. The woman is usually surrounded by close family members and neighbors and they all have a role to play. The following description from the field notes is of a child delivery involving both the *daya* and the *hakima* of the MCH clinic. It is a good example of the close working relationship between the paramedicals and the well trained *daya.* It also tells of various practices and beliefs surrounding childbirth:

When I arrived at the Health Center I found the *hakima* at the door, followed by her assistant carrying a bag over her head. She said was going to attend to a childbirth and I asked her to take me along. She said, "In the morning they sent for me, I went and found that the woman was in an early stage, so I asked them about their *daya* and they said it was Om Said. I told them to call her so that I could leave being sure that someone knowledgeable is at the woman's side. After I finished my other house calls I passed again and saw that the woman was very close to having the baby so I came to the Center to finish up some work and I am now returning again."

We went to Zeinab's house and the outside door was open. The house was full of children and women. Zeinab was sitting in a large circular basin on top of the oven while her sister-in-law (her husband's brother's wife) and her paternal cousin were supporting her. Zeinab's mother was standing beside her crying and lamenting that this was the first time that her daughter had had such a difficult labor. In the room were also Zeinab's sister, who was eight months pregnant, and a sister-in-law, who was two months pregnant. Om Said, the *daya*, was sitting in front of Aeinab. They all welcomed us warmly. When the *hakima* introduced me, they said, "May her entrance bring joy!" I climbed up with Fathia on top of the oven near Zeinab. Om Said then put on a white *galabeya* over her clothes and spread a piece of plastic cloth under Zeinab. She then made way for the *hakima* who took over with Om Said's blessings. The *hakima* asked for water and soap and one of the neighbors held a wash basin as she washed her hands. The *hakima* told Zeinab's mother, "If you are upset and will keep on crying it would be better if you leave the room. You go and heat some water." The mother said that the hot water was ready. The *hakima* examined Zeinab and said that the baby was going to be born very soon but urged her to help by pushing hard. The *hakima* kept dilating the cervix with the participation of Om Said. After a little while, the *hakima* said that the membrane had ruptured and got ready to receive the baby. They brought her a cooking pot with hot water, in which she put a few drops of Dettol. She dipped a piece of cotton wool in the water wiped Zeinab with it and said, "Now I want you to get up from this washing basin and to lie down." But Zeinab preferred to have the baby while sitting down in the basin. The *hadima* insisted explaning, "This will cause the uterus to prolapse."

Zeinab then lay down. When she again felt labor pains the *haikma* kept telling her, "Push down hard! Come on, Zeinab, hard!" But Zeinab relaxed and the uterine contractions ceased. The *hakima* reprimanded

her, "You have to help. Don't act like the peasants who will not make any effort during labor for fear that people may give them the evil eye for having had a quick and easy delivery. If you do that, you will harm yourself and the baby may die. Next time you feel the pain you must help." The mother said, "Why don't you get her Habiba's husband to give her an injection to increase the contractions so that she may have the baby quickly?" The *hakima* said, "If I thought that there was any problem, do you think I would have waited?" Om Said added, "What this Habiba and her husband do is pure ignorance and they could seriously harm a woman in labor." Zeinab again felt labor pains and the *hakima* told her, "Push hard, Zeinab!" Then everyone in the room started participating by screaming at Zeinab in a loud voice, "Push hard! Push hard!" Om Said and the *hakima* were in the meantime dilating the cervix until the latter was finally to get hold of the baby's head and help pull it down. She then raised it up by the legs until it cried. In all this she was very careful to hide his sexual organ. She placed him on the mat near his mother and pulled at the umbilical cord. Om Said then brought thread and scissors and helped the *hakima* tie and cut the cord. Om Said then took the baby in her lap while the *hakima* looked after the mother. She kept pressing Zeinab's belly and Zeinab yelled in pain; but she kept on until the placenta came down. Zeinab's mother was watching the whole operation, then the *hakima* told her, "Here is your daughter's placenta, all complete—look for yourself!" Fathia collected the placenta and gave it to Zeinab's sister. (The placenta has to be disposed of in the river or the canal by a trusted person, as it can be used ritualistically to bring harm to the woman. If the woman's babies do not usually survive, the placenta must be buried safely under the door step of the house.)

The *hakima* washed up Zeinab with water and Dettol and said, "Where is the cloth?" They gave her a piece of used cloth and Fathia placed it between Zeinab's legs. She massaged her legs and head with a gentle pressure then asked for soap and water to wash her hands. In the meantime Om Said was taking care of the baby. They brought her the baby's clothes; these turned out to be used pieces of unsewn cloth in which she wrapped up the baby after wiping his body and powdering it. (Some families do not like to bathe the baby right after birth; they may do so a week later. One woman who was subfecund and had an only one boy would not take a bath nor bathe her son for several years for fear he might die.)

Om Said wrapped the baby up in such a way that nothing showed except his face. Every one had announced that the baby was a girl, and

they kept talking and referring to it as a girl and said that they would name her Afrah (Happy Events). In fact, the baby was a boy and most likely everyone around knew it was a boy. Om Said wispered in my ear, "They say the baby is a girl so that he may not get the evil eye." After she dressed up the baby, she asked for a *ghorbal* (a large circular sieve with a mesh of thin strips of donkey hide). She placed the baby in the *ghorbal* in which Zeinab's mother had placed some hard salted biscuits. When I asked why they put the baby in the *ghorbal*, they explained, "So that no one would step over him." The baby will stay in the *ghorbal* until the *sebou'* (seventh day after birth). Some of the relatives present gave tips to Om Said, two piasters each. The *hakima* commented, "As you see, I deliver the baby and the *daya* takes the tips."

After a little while, Zeinab's mother brought ten piasters and gave them to Om Said saying, "This is from grandfather; it is the *bishara* (for the happy event) of cutting the umbilical cord." They explained that it is usually the grandfather of the baby who tips the *daya* for cutting the umbilical cord. They brought a quilt to cover Zeinab so that she would not catch cold. I asked if all deliveries occurred on top of the oven. They said, "Not necessarily. Every woman according to what she has become accustomed to. Many women like to have their babies in the animal shed. Zeinab wanted to have the baby there. She stayed for an hour and a half in the shed but nothing happened so we suggested that perhaps if she changed the place God might bring relief."

A quarter of an hour after childbirth, Zeinab's one year old daughter started crying. Zeinab's mother said, "Go, take her out of here!" But Zeinab asked for the little girl and she placed her by her side and started breast feeding her. The *hakima* said, "It is not correct for you to breast feed her because she is taking the baby's food." Zeinab retorted, "And what shall we feed her then? She will accept nothing else."

Zeinab's mother then came and told Om Said, "The water is ready, so go and take your bath," and she gave her a new scented soap. I asked Om Said why she took a bath. She said, "I must take a bath after every childbirth. The people of the house always prepare for me the bath." After the bath, Om Fathia, Om Said and I left the house after receiving an invitation to attend the *sebou'* (7th day celebration).

In the child delivery described above, the *hakima* happened to be present. The usual pattern, however, is for the *daya* to attend to the delivery herself. If the woman has been registered at the MCH clinic

during her pregnancy, the *daya* will simply notify the clinic of the childbirth so that the *hakima* may pay a home visit. If the mother has not been registered, the *daya* will register her after the delivery in order that she may receive postnatal care.

So long as childbirth proceeds normally, all *dayas* perform well enough. They leave nature to take its course with the minimum of interference. It is when complications occur, however, that the training of the *daya* makes a difference. The *dayas* are, of course, aware of childbirth complications resulting in difficult labor. They will naturally recognize an abnormal breach and a well trained *daya* like Om Said recognizes most complications. When asked about abnormal deliveries, Om Said was able to list most of the ones recognized by the medical profession:

> If I find that the baby is coming down with its arms first, when there is an incomplete breach (buttocks and feet first), a complete breach (buttocks only), or a face presentation; when the head is too large for the cervix or the uterine contractions too weak, I do not wait. I call for the ambulance immediately. I recognize a dead fetus when the woman discharges foul smelling forewaters. A woman with a heart ailment, if she has the baby easily, well and fine! But if she feels weak and faint, I send her to hospital.

The difference between someone like Om Said and the untrained *daya* is that Om Said will refer a difficult case to the doctor or the hospital early enough for it to receive adequate help. The untrained *daya*, on the other hand, does not always recognize the seriousness of the problem until a dangerous point has been reached. Speaking of Om Said, the village doctor said, "I personally hate Om Said because she is so skilled. She never calls on me except rarely and only when there is a serious case of difficult labor." He added jokingly, "Actually, I want her to drop dead so I can monopolize her clients. She is also the only one who recognizes cases with potentially serious complications. Whenever she calls on me for help, I always know it involves a real case of difficult labor."

The following incidents, recounted by the doctor, illustrate the danger of having *dayas* practice without receiving adequate training:

> Once a *daya* brought me a woman in labor and the baby's legs were already hanging down. The *daya* had walked the woman from the house to the clinic in order to speed up the labor, and that was very dangerous.

Habiba once called me. When I arrived, I found that the *daya's* husband, a "health barber," had given the woman a glucose injection (glucose in pitusin) to speed up the uterine contractions. The woman's pelvis happened to be too narrow and the uterus was about to rupture.

Once a man came to tell me that his wife had been in labor for three hours and that the *daya* was asking me to come and bring injections to speed up labor because the umbilical cord had already come down. Of course, that was pure ignorance on the part of the *daya*, because once the umbilical cord is down the baby must be rescued within half an hour or he dies. When I got there, I found that the baby had in fact been dead for two hours.

In their competition with each other, we find that each *daya* tries to surpass the others through better or extra services. Among the latter would be to help register the baby at the Health Center or to help around the house. One *daya*, when asked about the number of deliveries she attended in one month, said, "I don't deliver many babies these days. If someone calls me I go and help out. But I am too busy for this job." However, she soon confessed, "Now we have this woman in the village called Fakiha who has the time to do this job. She washes the women's clothes after childbirth; she throws out the placenta in order that people like her. Therefore many people go to her. She has taken all my clients."

Actually Fakiha, in addition to the fact that she offers extra services, has the advantage of having had six months training at one of the Ministry of Public Health training centers. She has also had practical experience working with *hakimas* in town. The following statement makes it clear that Fakiha's training does confer on her additional status:

Fakiha is the family *daya* and so was her grandmother before her. Fakiha has had training at the hospital in Menouf. She and her aunt stayed there for six months and they took their examinations; Fakiha passed, but her aunt failed. That is why in difficult cases we call Fakiha because she is educated.

Knowledge of modern medical methods has such prestige with the public that the *dayas* who possess it have a decided advantage over others in what is a tight competitive market. We find for example that Habiba, the *daya* mentioned by the doctor above, lacking both inherited initiation and formal training in her trade, nevertheless managed to gain a reputa-

tion simply by using a modern technique in which the Egyptian peasants have blind faith, that is, the injection. Her husband happens to be a traditional health practitioner, called the "health barber." The "health barber," in addition to shaving and cutting men's hair, circumcises, pulls out teeth, and provides cures for all kinds of petty ailments. This particular "health barber" had worked with doctors and had learned how to give injections. Aware of the peasants' belief in the magical potency of injections, he used his acquired modern skill to give special advantage to his wife over her competitors. Apparently he uses glucose in petusin and calcium injections to intensify uterine contractions during labor. Because peasant women feel that intensive uterine contractions mean a successful childbirth, the injection proved of devastating competitive value.

Even though according to the *hakima* and the private doctors in the village, Habiba is an unskilled *daya* and cannot handle complications, she she has managed to attract clients away from some of the more skillful *dayas*. One of them complains bitterly:

> There are people here who are practicing by sheer force, like this woman Habiba and her barber husband. She has got no one in the family who is a *daya*. She started practicing the trade after my mother's death (a famous *daya*). Since then she has been delivering babies and performing circumcisions. Her husband gives injections to the women during labor. She has been taking my clients and my aunt's clients and no one is punishing her.

Even Om Said, as respected and renowned as she is for her cleverness, experience and training, also feels keenly the competition of the magical labor-inducing injections. She complains to the *hakima*, "This Habiba is taking all my clients because of this injection .... She has so far taken twenty of our clients. And yet her mother was not a *daya* and I used to be the *daya* of her family." It is interesting that the injection is also mentioned by a *daya* as one of the reasons why the *hakima* has a higher status than the *daya*. "The *hakima* has greater prestige than the *daya* because she is educated and if a woman needs an injection she can give it to her."

Birth Control

What about women who wish to prevent conception? A *daya* answers with clear logic, "If a woman wants to become pregnant she comes to me and I will help her; if I cannot, I advise her to go to the doctor. But if she

has many children and wants to stop procreating, she would not possibly come to me. Is it conceivable that she would come to me and that I tell her to control pregnancy? Certainly not." The *daya* also refuses to help women induce abortion or to take care of a woman who has done so. The women of the village are aware of the *daya's* outlook on the subject, as the following remarks indicate, "The *daya* refuses to induce abortion. She says, 'I am afraid of God because that would be killing a soul!' If a woman has a natural abortion, the *daya* will come to her help; but if she induces abortion, the *daya* refuses to come." One woman did say that she had once asked the *daya* to help her have an abortion and the *daya* complied. She confessed, however, that there was a financial inducement—two and a half pounds, or about four times what the *daya* earns in one delivery.

The one service offered by the Health Center in the village which the *dayas* view as inimical to their own interests is, of course, family planning. In spite of the fact that they associated the interviewers with the family planning services, when asked their opinion about birth control the *dayas* as a whole frankly expressed a strong pronatalist attitude. They advanced arguments as to the value of large families and asserted that the number of children born to a woman is predetermined and a reflection of God's will. The *dayas* also expressed concern that family planning threatened their livelihood.

The following are some of the statements made by the *dayas* on the subject of family planning:

> Family planning means birth control. After having three or four children, women then take pills to prevent pregnancy. There are those who get two boys and one girl and then decide that that is enough, and there are others who have a large number of offspring and still say about children, "The happy man and the happy woman, and the ones begging on the mat; if we are rich they will plough for us; if we are poor they will beg for us." The proverb means that procreation is always a good thing and can never be abhorred. Children can be a burden at first, but later on when they grow up they will benefit us.

> Procreation is by God's order. One woman gets one child and it never gets registered (that is, it dies), but another gets ten and then twenty. The number for each woman and man is predetermined and it is God who determines all. As for these pills, I know a woman who used to have a baby every year until she had eight children. She was in a terrible state; her house was filthy and she could not provide for these children. So she decided to take pills. She took them for a year but she had a hemorrhage; she stopped and became pregnant again.

There are people who have six children then stop, and there are others who have one child and also stop. However, each woman gets her predetermined quota. I don't approve of birth control; it is sinful to oppose God. It is God who gives all; how can we possible prevent him from giving? If a woman wants to practice birth control and comes to ask me, I will have nothing to do with the business. This is God's affair! And there are people who are harmed by these contraceptives; others do all right. The poor cannot afford to buy restorative medicines to take with the pills; and as a result, if they take pills, their health deteriorates. There are people who say, "The money I will pay to buy the pills I can spend to feed my children."

Family planning means to have fewer children in the world. We have been hearing about it for two years and now it is spreading until the world will come to an end. Anyone who gets to know children can never hate them. . . . The most suitable number of children is six because a large family is a good thing and every person can provide livelihood.

Family planning means there are too many people. Children are numerous and people practice birth control in order to be able to bring up the children they already have. I heard about all this since the day the pills were brought into this village. (She laughed.) You family planning people have taken the bread from our mouths.

Frankly, I want people to have children every day. Supposing a woman does not want to prevent pregnancy, what do I gain by going and telling her to practice birth control? People believe that birth control is sinful. You know, right after the day they began to count houses (for the census) a pestilence hit the village and the animals died by the hundreds. The village was terrified. The onions would not grow and the land produced nothing!

I had three deliveries only last month. The *daya* with the larger number of clients is Om Said. You see the pills have had a terrible effect on our trade.

The *dayas* had a few derogatory remarks to make about the main contraceptive method prescribed by the family planning clinic, that is, the pill. They tried to discredit it by asserting either that it was ineffective or harmful. They claimed the pills "cause hemorrhage," "are debilitating," "ruin a woman's health," "do not prevent conception," etc. Still, the *dayas* admit that under certain conditions a family may desire no more children. Two *dayas* even surprisingly expressed themselves in favor of

family planning. "I think a small family is better than a large family, of ten for example," said one of them. "I approve family planning, it is not harmful and I have never had heard of anyone feeling unwell because of the pills." The other said, "Three children would be fine. I wish I had three children only, because a large family if it is poor always has a hard time. Four children, a father and a mother would be a good family size. They would not be like my children whom I have to keep home as I can't afford to send them to school." However, it is difficult to tell whether these *dayas* were not just being obliging to the interviewers whom they believed to be family planning workers.

Postnatal Care

The following is a field account of what the *daya* does on her first postnatal visit:

> We went to visit Fatma, whose baby Om Said had delivered two days earlier. Fatma was sitting in front of her house participating in a quarrel between her sister and a neighbor. When she saw us she got up and went inside with us. Om Said reprimanded her, "It is not proper for you to get involved in a quarrel; you are still soft and are not yet healed." Om Said then picked up the baby who was sleeping in the *ghorbal*. She untied the wide belt wrapped over his naval and put sulfa powder on the wound. She wrapped the baby up again and put him in the *ghorbal*. Fatma said, "I have colics that are killing me!" Om Said asked, "Have you taken the injections and pills I sent you?" Fatma answered, "They only reached me at night and now I am going to send for someone to give me the injections." I asked Om Said about the injections and she said, "These are injections the doctor at the Health Center gives to me for the parturant women; the pills are Novalgine pills to relieve the pain."

On the third day after childbirth, the *daya* attends to the baby's eyes. She "splits" his eye, as the *dayas* put it, and puts in eye drops or zinc oxide powder. The latter is an eye disinfectant that was once commonly used by the medical profession. Some old fashioned *dayas* also use a few drops of onion juice with the zinc oxide and some use zinc sulphate powder to line the baby's eyes. The MCH clinic personnel have been advising the *dayas* to use silver nitrate instead of zinc oxide, as the latter is not effective against neonaturum ophthalmia. An old fashioned *daya* gives an account of what

she does on her third visit, "On the third day we split the baby's eyes with a match and squeeze onion juice into his eyes and now the *hakima* has done away with *shishm* (zinc oxide powder). The fashion now is for everyone to put eye drops."

During her visits, people may ask the *daya's* advice if the baby is not well. She may recommend some simple cures but she usually refers them to the doctor. "If the baby is ill or has a temperature, the woman asks my advice. I tell her to give him one feeding of warm mint or cumin instead of milk and I take her to the doctor of the Health Center." The *daya* will also advise the woman to go to the doctor if she sees that the latter is not in good health, "If the parturant woman herself has a temperature or seems not to have regained her strength, I warn her so that she may go to the doctor."

If a woman does not have enough milk to breast feed the baby—a serious problem for poor people—she consults the *daya*. The latter may suggest that the woman eat special kinds of nourishing foods. Usually, however, the diagnosis is that the woman suffers from the spell of *mushahra*, a spell that can decrease the flow of milk, as well as cause sterility. Since medical science does not offer the *dayas* simple remedies for serious lactation problems, the explanation and the cure are of course totally traditional. As with most mysterious happenings, there are magical explanations and magical solutions. The *daya*, as the repository of such occult wisdom, is here the trusted oracle.

The cure is always a ritual involving some act or feature that is also common to the cause. In the case of a lactating woman, the following are some of the possible causes of *mushahra* and their suggested remedies:

Cause: A visit from a woman who has recently had an abortion or whose new born baby had just died.
Cure : The lactating woman must take a few drops of milk from the breast of the visitor and swab her own breasts with them.

Cause: A visit from a woman who recently stopped breast feeding her child.
Cure : The lactating woman must scratch the visitor and lick some of her blood.

Cause: A visit from a man who has just had a shave.
Cure : The barber's tools are placed in water for a while and the woman then washes her breasts with the water.

Cause: The visit of a cat or a bitch that has just given birth.

Cure : The woman must see a cat or a bitch give birth.

Cause: The sight of raw meat, fresh lemons or eggplant.
Cure : In the case of the raw meat, the woman goes to the slaughter house and jumps over animal blood; for the lemons, she squeezes a few drops on her breasts; for the eggplant, she walks through a field of eggplants.

The Sebou'

On the seventh day after childbirth, the important *sebou'* celebration takes place. It coincides with the end of the dangerous period for the parturant woman and with the healing of the baby's navel. On this occasion the *daya* is the mistress of ceremony. In this role she does not have to share the limelight with paramedicals or doctors. The *hakima* of the clinic admits, "Each family has a *daya* and she performs the *sebou'* celebrations. We do not know how to do these things."

On the eve of the *sebou'*, the *daya* visits her client to make all the necessary preparations for the celebration. She soaks horse beans in a tray in which stands a jug of water. The jug is one that is especially made for the *sebou'*; it is painted in bright colors and has holes for holding candles. The jug of a baby boy has, in addition, a spout. The *daya* fills the jug with water, lights the candles, and places a gold necklace around it. She also collects seven kinds of grain and dried beans—wheat, barley, rice, alfalfa seed, horse beans, white beans, lentils etc. The tray with all its paraphernalia and the seven kinds of grains and beans are placed over the child's head all night. The water, the light, the food and the gold are all obviously symbols of plenty and good fortune.

The following field report gives a description of what takes place on the *sebou'*, the *daya's* big day:

I asked Zakia about the *sebou'* celebration and she said that she had one that day and invited me to go with her. We went to the house of Om Hasna. She greeted us saying that her daughter was lucky because I was going to attend her *sebou'*. I believe she thought I was from the Health Center. The mother brought a jug of water in a tray containing beans soaked in water on the previous day. Zakia gave out instructions and orders and the mother quickly complied with all her demands. Zakia asked if the fire was ready and Om Hasna brought a clay pot in which corn cobs were burning. Zakia put salt on the fire and the mother, carrying the pot on her head, went around the whole house, the *daya* followed carrying the baby. She sprinkled salt, beans and grains and

while chanting, "May your ears have golden earrings." Om Hasna placed the pot at the door step and she crossed over the fire seven times. By then the neighbor's children and relatives had started to come. Zakia sat on the ground with the baby girl in her lap. She started to string the soaked horse beans into necklaces for the little girls standing all around her. In the middle of each necklace she made a loop with seven beans. For each of the boys she made a string of seven beans. As the relatives and neighbors walked in, they gave the *daya* a tip and she showed it to Om Hasna. The tip ranged from one to five piasters. The mother was the only one who gave a tip of ten piasters.

Then Hasna's husband's sister came in carrying a ten-day-old baby. She was very angry and told the *daya*, "You sent asking for a tip. Did any of these people here, including my mother, come to my *sebou'* and give you tips? Who of my brother's wives paid you any attention?" Her mother said that they had sent the money, but that *daya* had by then finished the ceremony and that they had forgotten to send the money later on.

Om Hasna brought a paper bag full of dates and peanuts and gave some to each of the guests (other families offer rice pudding and distribute sweets). Om Hasna then brought a bowl in which Zakia put salt, *fasookh* (special insence), alum and a piece of soap, then sprinkled some of the salt and the *fasookh* on the fire. The *daya* (sometimes the mother) then carried the baby around all the rooms of the house, sprinkling salt, beans and grain and chanting:

"Oh salt of our household
Increase our children and keep our men.
The first sprinkle is salt and beans;
The second is for the Prophet;
The third is to prolong his life.
Make your steps, step by step.
The first sprinkle is in the name of Allah;
The second in the name of Allah (repeats seven times).
Oh God of the East and West,
Allah who conquers the conquerors,
I protect you from your eyes and his eyes;
From the eyes of your grandmother;
The mother of your father, and your mother's eyes;
And from . . ." (goes on pointing to all those present).

Among those attending the *sebou'* was one of Om Hasna's sisters-in-law and she was unhappy because her year-and-a-half-old son was ill. She

said that he refused to feed at the breast and that he had a high temperature. Zakia said, "You are to blame for the child's illness. After he was born, you started to take those pills (contraceptive pills) and I warn you that they may cause that child to die." The woman answered, "If this is so, then I shall stop the pills."

At one point an old woman came and gave half a piaster to the *daya* and said, "This is for good fortune from his great aunt." Then she left. The women present told the *daya*, " This half piaster is for the *higab*." (the *higab* is talisman to be worn by the baby for good fortune and against the evil eye). They explained that the woman who gave it was a begger and that it is preferable if the money put in the *higab* has been obtained originally as alms (or money from an old woman who is not likely to have any babies or *sebou'* celebrations, so that her gift of a piaster will not have to be returned. This means that the piaster will remain unreturned and thus the baby will keep the good fortune. All the child's clothes should also be old borrowed clothes, as it is believed that that gives him better chance of surviving. Om Hasna said, "I must put five piasters in the *higab* for the baby, for I have been longing for the day when I can hear a baby's voice in the house." The other women laughed as it was not usual for anyone to put more than one piaster, and they said jokingly that they would come later on and steal that money.

The *daya* explained to me that the *higab* will consist of a small sack made of cloth containing a piaster, to which is sewn a string of seven beans. This will be tied to the baby's belt and will remain there until it is old enough to open the sack, take out the piaster and spend it.

The *sebou'* celebration lasted one hour and a half, at the end of which everyone left except close relatives (Om Hasna's sister, her mother and mother-in-law), the *daya* and myself. Om Hasna brought a low table with food on it—boiled eggs, a bowl of cream, cheese, and bread. (Better off peasants also offer meat or chicken). Everyone ate except Om Hasna. I asked the woman why Om Hasna did not eat and they said, "She must have just eaten her chicken." Her sister said, "They cook for one a chicken but I never could eat it alone. I always gave the children to eat and I would be lucky to end up with one quarter."

During the *sebou'* the *daya* takes care of other business. Om Hasna brought her husband's identity card and his seal and said, "Take these with you to register the baby at the Health Center; her father is staying in the fields and cannot go himself." A little later the *daya* took out of her pocket a little paper parcel and told one of the women present, "Take the *shishm* (zinc oxide) you wanted for your boy." (I did not

comment on the fact that she had told me that the Health Center had forbidden the use of *shishm* for baby's eyes and that she had said that she never used it.)

After the *sebou'* celebrations, the *daya* may still maintain some relationship with the baby she helped deliver. She may call to remind the mother about the time of vaccination or she may take the baby herself to the MCH clinic to have it vaccinated. She may be consulted if the baby is not feeling well and may prescribe simple remedies, such as scrubbing the sick baby with alcohol or vinegar, giving it castor oil, etc. Most often, however, she prefers to refer a sick baby to the Health Center or to the doctor to avoid any blame in case of an unsuccessful attempt at a cure.

Circumcision

The next important function the *daya* exercises is when a baby girl becomes a few years old and is ready to be circumcised. A number of the *dayas* in the village specialize in circumcision of girls but not all *dayas* can or like to perform this operation. Om Said, for example, declares haughtily, "*Circumcision* is not my trade; it would be shameful and beneath my status to perform it. This is a trade for the gypsies who go round the village." She admitted however, in the same breath, "Soad, my niece, performs circumcisions." Other *dayas* mentioned that they would be reluctant to circumcise girls for fear that "people may shame our sons and tell them 'your mother is a clitoris cutter!'"

One should, however, take Om Said's and the other *dayas'* disparaging remarks on circumcision with a grain of salt for they may simply be motivated by competitive jealously. Circumcision does bring the *daya* extra remuneration of between 10 and 50 piastres, depending on the wealth of the family. Those who perform circumcision naturally boast of their skill. "Circumcision is a job that needs special adroitness, for there is always the danger that hemorrhage may occur and in such a case the doctor must be called."

In circumcision, the *dayas* have also learned to use modern medicine. "After cutting the clitoris, I sprinkle some *henna*. The truth is that in the old days they used to put *henna* but now we put mercurochrome, sulfa powder and sterilized bandages." Some traditional notions, however, still remain. "I perform circumcision only at a certain time," explains one *daya*, "that is when the Nile is high and the corn is green. This is because the water at that time is good and it makes the grapes and the watermelon sweet. So if the girl washes in the water of the fields, the wound would be nice and would not pucker up."

The Wedding—Deflowering of the Bride

When the little girl becomes a young woman, sixteen or seventeen years old, she may again find the *daya* attending to another important event in her life, the wedding. In preparation for the wedding, there is "the day of the henna" when the *daya* stains the palms of the hands and soles of the feet of the bride-to-be with the ochre colored henna. On the wedding day itself, the *daya* may help in the important deflowering ceremony. "Here in the village," explains a *daya*, "the girl's honor is very important. Since girls work in the fields and are exposed to men, a bride's parents insist on her being deflowered in public so that everyone will know that she is a virgin. Some bridegrooms would like to deflower the girl themselves in private, but parents refuse for fear someone may say later that she had not been a virgin."

To prove the bride's virginity, the hymen is broken with the finger in the presence of close female relatives. This may be done by the bridegroom himself but often enough by the *daya*, usually the same *daya* who will eventually attend to the bride's future pregnancies and childbirths. The following is a description of the ceremony and the *daya's* central role in it:

The bride's room was small and dark but in it were twenty women and children. The bridegroom stood at the door and the bride sat on a chair. She had a piece of white gauze over her head and a red satin dress. The women and children outside the room were singing wedding songs.

The *daya* started to arrange the room for the hymen-breaking ritual. She asked for a gas lamp so that she might be able to see. She removed the chairs that were crowding the room and had the bride sit on a mat facing the light. Throughout, the *daya* acted as if she was the owner of the house and the organizer of the wedding. At about seven o'clock in the evening, the bride's mother said it was time for the bride to urinate, for it was getting late and it would soon get dark. The bridegroom went into the room and sat waiting for the bride to return. There were many women in the room including the bride's mother-in-law, her aunt, her mother, her sister-in-law and a few children. The bride walked into the room and the *daya* removed the piece of gauze from the bride's head and told the people present, "I do not want any noise or ululations until I am through." Then she closed the door. Outside were some women and girls singing and they said, "Call on the men quickly." Four or five young men came and stood by the door. Inside the room, the bridegroom held the bride as all the women and children in the room looked on. The *daya* then wrapped the piece of gauze around her index finger and broke the bride's hymen, who let out a cry and fainted.

Immediately after, ululations, clapping and singing broke out inside and outside the room. The *daya* then opened the door and gave the piece of gauze spotted with blood to the jubilant young men waiting outside. They hung up the gauze over four sticks and went around the village displaying the proof of the girl's virginity. In the meantime the women were reviving the bride by sprinkling water over her face and by giving her rose syrup to drink. The *daya* stood there proud of her success and received the tips from the women present—five piasters or so from each and from the groom, ten piasters.

In the case of the girl who loses her virginity before marriage, the *daya* again comes to the rescue. This is a *daya*s account of what happens when such "accidents" occur:

If a girl becomes pregnant, her family will take her to the doctor in town to have an abortion. The *daya* will have nothing to do with this; the girl may hemorrhage and that would be a serious responsibility. If a girl loses her virginity, she naturally informs her mother because the mother is the keeper of a girl's secrets. The mother then comes to us and we must help cover up for the girl. Her family pays the *daya* in secret—at least one pound over and above what the bridegroom pays on the wedding day. If the person responsible for the accident happens to be the fiance of the girl, then it is he who comes to ask for help, and he is then quite willing to pay at least a pound for the deflowering ceremony instead of the usual 15 to 20 piasters. What the *daya* does is to scratch with her nails the girl from inside and this way a great deal of blood comes down, sometimes in even greater quantity than when the girls is deflowered. The only thing is that the wound stay painful for a while, at least 10 days or so until it heals.

Conception

Soon after the wedding, the families of the bride and the groom wait anxiously for signs of pregnancy. Should the bride become pregnant fairly soon, all is well. Should the months pass without anything happening, something must be done, for sterility for a peasant woman is a terrible affliction. She may risk divorce, or may have to share her husband with a second wife. The following account illustrates the anguish caused by the possibility of female sterility:

My daughter got married twice, the first time to her maternal cousin. He took her to Cairo. There he became acquainted with another woman, then he divorced my daughter with the excuse that she was sterile. When after her second marriage time began to pass and there was no sign of pregnancy, I began to worry; for if a relative could not stand it, how could an outsider?"

I fixed for her some suppositories dipped in Ichtyol solution and I had her wear one every day for three days following the menstrual period, but this brought no result. Her husband said that he wanted to take her to a doctor because he himself had been married before and had children. I waited until the day her husband went on a trip and I took her to the doctor at the Health Center. The doctor said she had a "weak" uterus and needed a complicated cure. I became very unhappy and miserable. I returned to my husband and told him the story and said that I was afraid her husband might take her to the doctor again and then he would learn the truth. My husband asked me to take her to Cairo to Dr. H. (a woman doctor whose family came from that village). I did and the doctor said she needed an operation after which she would be able to conceive; and if she did not become pregnant within six months, the husband must go and have a test.

After the operation, the doctor told my daughter not to sleep with her husband for seven days. I took her home and kept her for 40 days as an extra precaution so that our money would not have been paid out in vain. The day she returned to her husband's house, she became pregnant. Her husband had marked that day on the wall and nine months later she had the baby.

The *daya* is immediately consulted if there is no sign of pregnancy and she may prescribe any one of several possible remedies, depending on her diagnosis. Pregnancy may not have occurred because the young bride was exposed to cold when she was deflowered, in which case the cure is to apply air cups to her back. On the other hand, she may be a victim of the evil eye or of *mushahra*. The causes of the latter may be similar to those discussed earlier in relation to lactating women. Some of the cures may involve crossing over placenta, visiting the slaughter house, taking a bath in the canal early in the morning, washing with water in which blood resulting from the rupture of the hymen has been dissolved, etc. Each *daya* possesses a special necklace, handed down from generation to generation, that can also be used to neutralize the effect of the evil eye and the *mushahra*. The necklace is dipped seven times in water with which the woman then washes herself. "She would become pregnant right away."

affirms the *daya*. Another common cure is the *sufa*, a suppository made of cotton wool daubed with some ingredient believed to be potent against sterility (sugar, fenugreek, etc.).

If traditional remedies fail, modern methods may be used such as suppositories of cotton wool dipped in Ichtyol solution, as was mentioned in the story reported above; and if, in turn, the modern methods fail, the woman is referred to the doctor. "Many women come to me," says Om Said, "because they want to become pregnant. I prescribe vaginal suppositories and douching powder and I teach them how to use them. If nothing works, I advise them to go and consult the doctor."

The *daya* does recognize the possibility that the man himself may be sterile. The cause may be due to his having suffered a shock. In such a case, he may be cauterized, or he may consult a doctor. The *daya*, however, has nothing to do with male sterility.

Conclusion

It is evident from the above description that the *daya* of rural Egypt has survived the onslaught of new ideas and practices and has achieved a remarkable adjustment within a modernizing society. Her success can be mainly attributed to the fact that it was not a sudden and enforced adjustment but an evolutionary process brought about by education and persuasion. Much of the credit goes to the Ministry of Health, which provided opportunities for the unlettered *daya* to be educated in modern practices in obstetrics but left her free to incorporate her newly acquired knowledge into her own work as she saw fit.

The well trained *daya* seems herself to have learned in the process not only what to do to improve her performance, but what is more important, to recognize the limits of her own expertise and capabilities. Furthermore, she has also been instrumental in the diffusion of new knowledge to the community itself, so that she has herself become an agent of modernization, and indeed an effective one. She is effective because she is able to introduce new ideas with the sensitivity and the pragmatic intuitiveness of the insider, for she is rooted in the same folk culture and hence attuned to the basic orientation of the group she serves. Her response to new ideas is therefore likely to be congruent with that of the village community and what she accepts of the new knowledge or retains of the old lore is likely to reflect the community's own basic judgements.

It is to be regretted that those responsible for public health policies view the traditional *daya* as an anomaly in a modernizing society. It is understandable, of course, that Ministry of Health officials should feel that, since they are providing for the education of large numbers of nurse/midwives, or *hakimas*, the traditional *daya* is expendable. I believe that this is

not a realistic evaluation of the situation. The traditional *daya* will automatically become extinct only when she stops being useful or adequate, not in the eyes of government planners, but in the eyes of her clients. A better educated public will demand a better educated midwife. The natural evolution is, perhaps, for the trained *hakima** eventually to replace the illiterate *daya*; but that can only happen when enough of the former become available in the villages to meet the demand, and when the numerous social and ritualistic functions which the *daya* discharges are no longer compatible with the needs and understandings of rural society. In Egypt's larger urban areas one suspects that the replacement of the *daya* by the *hakima* is happening fairly rapidly. In the rural areas, however, the process may have just started or, as in our study village, has not even begun. Therefore, it is important that the *daya* should continue to be recognized and trained for the sake of those who will continue to depend on her services for a long time to come.

The *daya*, moreover, has special qualities that may very well be lost when the professionals take over. First of all, she communicates in the idiom of the women she serves. Secondly, she is readily available, relatively inexpensive, and is able to give the time and comfort her clients need. Thirdly, since her success, and hence her livelihood, are dependent upon the public's evaluation of her abilities and skills, her efforts are conscienciously expended towards giving satisfaction and providing the best services she can. On the other hand, the public—especially the poor and the powerless—lack this leverage in relation to public health services, since it cannot apply any pressure in case of unsatisfactory or inadequate service.

The acceptance of the *daya* by the local health personnel in the village under study is a very fortunate development and has been of great benefit to the village community. As the description of her role demonstrates, she has become the liaison between the MCH clinic of the Health Center and the village women. She is the extension worker of the MCH program and the main channel for the propagation of better maternal health practices. She has also been effective as a screening and referral service, taking care herself of all the cases she can handle and referring to the public health services those in need of special medical attention. In this way she has lightened the burden on an already overextended health service, thus allowing it to give more concentrated and better service to the more complicated cases.

Whereas the functions of the *daya* are completely compatible with the maternal and child health services, they are totally incompatible with

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*There is a nursing school in each county that provides three years of training for nurses and nurse/midwives, following nine years of general eductation.

those of family planning. No efforts have been made to relate the *daya* in any way to the latter and she, quite rightly, sees the service as a threat to her livelihood. Whatever subtle influences she can wield to keep people away from family planning the *daya* will certainly use. On the other hand, the *daya* does recognize the fact that women may at one time or another during the reproductive years, wish to avoid pregnancy.

Since the country considers a family planning program of top priority, it is necessary to find a way of minimizing the negative influence of the *daya*. I believe it can be done. The approach should not be to demand that she develop a split personality, propagandizing birth control on one hand and anxiously waiting for signs of pregnancy on the other. The aim should be to minimize the *daya's* active antagonism to family planning efforts by allowing her to gain some benefit from the program. Since the latter involves mainly the sale of contraceptives, namely the pill, it may be worthwhile to allow the *daya*, at her own discretion, to sell the pills and keep the revenue for herself. At the present time, the pills are sold at the Health Center at five piasters a cycle and the income is distributed among the personnel. If the *daya* sells pills, she may not then look upon every pill user as a potential client who has been lured away from her. Experience may also eventually show her that a habitual pill user may be as lucrative a client as a childbearing woman. At five piasters a cycle, the *daya* can collect every two years what she earns in one delivery—120 piasters. A practically minded *daya* may very well conclude that once a woman has decided to practice birth control, she need not lose her as a client. An aging *daya* may also find the sale of contraceptives something to fall back on when she begins to feel the strain of a demanding profession.

In conclusion, I hope that this paper has shown that at this stage the *daya* is entitled to something better than abolition. She has done a very commendable job and, like the widely acclaimed barefoot doctor of China, she can provide a practical and inexpensive solution to the problem of providing better health services in a developing country.

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